

Division of Health Improvement

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5788 | (X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/21/2009 |
|---|--|--|---|--------------------|---|
| NAME OF PROVIDER OR SUPPLIER VILLAGE AT NORTHRISE-MORNINGSIDE (THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2880 N ROADRUNNER PARKWAY LAS CRUCES, NM 86011 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| A-01 | <p>OPENING REMARKS</p> <p>A complaint investigation was completed for Intake NM00027387. The facility self reported the employee for exploitation. The employee information was sent to the Employee Abuse Registry to be listed. The facility was not cited for deficiencies.</p> | A-01 | <p><i>Scanned 4-30-10 JL</i></p> | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] ADMINISTRATOR 4/29/2010

STATE FORM

8999

MGT-11

If continuation sheet 1 of 1